DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 04-04	2. STATE New York
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2004	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.204	7. FEDERAL BUDGET IMPACT: a. FFY 01/01/04 – 09/30/04 $254,565 b. FFY 10/01/04 – 09/30/05 $339,420
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 16(a)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: To replace Attachment 4.19-B, Page 16, Hyperbaric Oxygen Therapy

10. SUBJECT OF AMENDMENT:
Non-Institutional Services – Hyperbaric Oxygen Therapy

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Kathryn Kuhmerker	16. RETURN TO: New York State Department of Health, Corning Tower, Empire State Plaza, Room 1466, Albany, New York 12237
13. TYPED NAME: Kathryn Kuhmerker	
14. TITLE: Deputy Commissioner Department of Health	
15. DATE SUBMITTED: December 30, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MAR 16 2004
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2004	20. SIGNATURE OF REGIONAL OFFICIAL: Sue Kelly
21. TYPED NAME: Sue Kelly	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

OFFICIAL

New York
16(a)

Attachment 4.19-B
(01/04)

Hyperbaric Oxygen Therapy (HBOT)

The Department of Health will continue to conduct a pilot reimbursement program for a period of three additional years to study and determine the efficacy of funding certain outpatient HBOT services provided by select hospitals in New York State.

(a) Hospitals will be selected based upon their experience in providing outpatient HBOT services and pending appeals to establish specialty outpatient HBOT rates of reimbursement, which were submitted to the Department no later than January 25, 2000. In order to participate in the program, such hospitals will be required to submit quarterly reports to the Department that include specific measurable outcomes in order to determine the effectiveness of the program.

(b) Outpatient HBOT services covered by Medicaid in this pilot program include only those listed in Section 35-10A of the Medicare Coverage Issues Manual published by the [Health Care Financing Administration] Centers for Medicare And Medicaid Services.

(c) The payment rate for outpatient HBOT services provided in accordance with Section 35-10A of the Medicare Coverage Issues Manual shall be the current Medicare APC rate paid through the hospital outpatient prospective payment system.

TN 04-04 Approval Date MAR 16 2004

Supersedes TN 01-05 Effective Date JAN 01 2004